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ABSTRACT

This report examines the place of children in the employment-based health insurance system. The report, which uses data from three national studies conducted by the Federal Government between 1977 and 1990, estimates the number of children who are uninsured or underinsured and examines the decline of children's private insurance coverage between the late 1970s and late 1980s. The first section of the report discusses racial and ethnic characteristics of children without employer-based insurance, insurance coverage among children living in families, and the role of Medicaid. The second section reviews insurance coverage among minority children, and trends in insurance coverage of children in terms of family income level, parents' employment status, and place of residence. Tables presenting data relevant to these topics are provided. It is concluded that a national health program that assures access to health care for all children is needed. A national health plan should have three components: (1) access to health insurance for all families; (2) funding for the development of health services in areas suffering from a shortage of primary health care; and (3) the maintenance of a basic public health infrastructure. Technical notes concerning the three studies upon which the report is based are appended. (BC)

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Special Report

CHILDREN AND HEALTH INSURANCE

January, 1992

Sara Rosenbaum*
Dana Hughes**
Phyllis Harris***
Joseph Liu***

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OVERVIEW OF KEY FINDINGS

Over the past decade, the proportion of children without employer based health coverage increased dramatically. In 1990, more than 25 million children under age 18 -- 40 percent of all American children -- lacked employer health coverage, even though more than 85 percent of all children lived in working families. Of the 46 million children with private coverage during 1990, approximately 43 percent -- nearly 20 million -- will experience some period without coverage by the end of 1992.

Between 1977 and 1987, even as employment in the U.S. reached record levels, the proportion of children with employer health coverage declined by nearly 14 percent (almost 3 million children). If this trend continues unabated to the end of the century, then by the year 2000, half of all children, and more than 80 percent of all black children, will be without employer health insurance -- the principal form of health insurance coverage for working age Americans and their families. Since 1987 was an economic recovery year, before the current recession and the cutbacks it has produced in employer fringe benefits, the actual decline in children's coverage by the year 2000 could well be much greater.

According to statistics from the U.S. Census Bureau:

- A full third of all white children lacked employer coverage in 1990. Of the 25 million children without employer coverage, 17.5 million (70 percent) were white. These children comprised 77 percent of all uninsured children that year.

- More than 60 percent of black children and the same proportion of Latino children lacked employer health insurance in 1990. For these children, employer insurance is now the exception rather than the rule.

- Medicaid is a vital source of coverage for children. Without Medicaid, the number of completely uninsured children (which in 1990 stood at 8.4 million) would have risen to more than 18 million. This underscores the importance of recent Medicaid expansions for children. Yet as important as they are, the Medicaid reforms (along with legislation providing tax credits for poor working families who cannot afford the cost of private health insurance for their children) have barely made a dent in the problem. The collapsing employer system for children in low and middle income households (annual incomes of between $11,000 and $46,000 for a family of 4 in 1991) remains unaddressed by Medicaid reforms for poor children.

The decline of the employer health insurance system for children has been felt most acutely among children in moderate income, working families and has cut across all racial and ethnic groups.

Statistics from the 1977 National Medical Care and Expenditure Survey (NMCES) and the 1987 National Medical Expenditure Survey (NMES) show major declines in employer insurance coverage among low and middle income children and children living in working families:

- Even in 1977, when employer based health coverage was broader than it is today, only 72.8 percent of all children had coverage. By 1987, in the midst of the longest period of economic recovery since World War II, the proportion of employer-insured children had dropped to 62.9 percent -- a 13.6 percent decline over a decade. If the proportion of privately insured children continues to decline between 1987 and the year 2000 at the same average annual pace, then by the end of the century only half of all children (50.0 percent) will have employer coverage.

- Between 1977 and 1987, the proportion of children in low income families (1991 incomes between 100 percent and 200 percent of the federal poverty level) with employer coverage declined by more than 25 percent, from 63.4 percent to only 47.0 percent. Coverage among middle income children (with family incomes between 200 and 400 percent of poverty) declined by 5.5 percent over the same time period.

- The "traditional" American family -- a two-parent family with a single wage earner -- has been hit particularly hard. Children in these families experienced an 11.7 percent decline in the proportion with private insurance. As employer-based coverage evaporated, the percentage without any coverage soared. The proportion of these children with no insurance at all climbed from one in nine to nearly one in five, a 64 percent increase Increasingly, the decision to remain at home to care for children means a loss of insurance coverage for them.

- Declines in the proportion of children with employer coverage were seen among all types of employed families, including two-parent families with two-wage earners and single-parent working families, as well as the "traditional" family.

- As the percentage of employer-insured children in working families dropped between 1977 and 1987, the proportion of completely uninsured children living in working families increased dramatically. Among children living in two-parent families with two-wage earners, the proportion increased from one in sixteen to one in ten, a 63 percent increase. In single parent working families, the proportion of completely uninsured children grew from one in eight to more than one in five, an increase of 67 percent. If these trends continue, then by the year 2000, nearly 20 percent of all children in two-parent, two wage earner households could be completely uninsured.

These increases were the result of the decline in employer coverage, the absence of any public insurance safety net for children like the Medicare program for the elderly, and the very limited reach of Medicaid into the ranks of working families.

- More than 85 percent of uninsured children living in two-parent, working families had at least one parent who worked more than 30 hours per week in 1987. Among children living in single parent working families, nearly 60 percent had a parent who worked more than 30 hours per week.

- Both urban and rural children lost private coverage over the 10 year time period. The proportion of privately insured children in metropolitan areas decreased from 76.7 percent to 70.1 percent, an 8.6 percent decline. Among children living in non-metro areas, the proportion with private coverage decreased from 73.8 percent to 64.1 percent, a more than 13 percent decline.

- While all children were affected by the loss of coverage, minority children were particularly hard hit, given their greater poverty and the greater likelihood of parental employment in low wage jobs with few, if any, fringe benefits. Between 1977 and 1987, the proportion of black children with employer insurance fell by more than 27 percent, from 52.5 percent to 38.1 percent. Among Latino children the proportion of employer insured children declined by more than 22 percent, from 50.7 percent to 39.4 percent.

The Medicaid reforms which have occurred over the past decade have prevented an even worse crisis. But they do not reach the children who proportionately have been the most affected by the loss of employer coverage. Only major national health reforms that guarantee children uninterrupted, comprehensive health insurance coverage regardless of family income, work status or family living arrangements will assure a healthy start for every American child. Such reforms should also provide for the development of primary health services in areas without sufficient medical personnel and for the support of broad, population-wide public health activities, including immunization programs and other preventive health services.

"The strength and energy of a society may be measured today and predicted for tomorrow by the health of its children. Robust bodies, bright eyes, sharp minds: all of these define the quality of life in this country now and for the future." President Richard M. Nixon, Presidential Proclamation for Child Health Day, 1971

INTRODUCTION

Nothing is more important to a family than knowing that its children have access to necessary health care. Whether for preventive and routine check ups, prenatal care, immunizations, dental care, eyeglasses, or medical care for acute or chronic health problems, children have a fundamental and absolute need for comprehensive health care.

But even basic care is increasingly beyond the reach of millions of American children. For a half century the nation has relied on a voluntary employer based system for insuring working Americans and their families. Yet in 1990, forty percent of all American children -- more than 25 million -- lacked employer-provided health insurance. If the decline in employer insurance coverage among children which occurred between 1977 and 1987 continues unabated through the year 2000 (and given the recession which now grips the nation there is every reason to believe that the rate at which children are losing employer health insurance may well accelerate), then by the end of the century only half of all American children (50.0 percent), and less than 20 percent of all black children, will have employment based insurance.

The loss of employer health insurance has affected all racial and ethnic groups, urban and rural regions, and all but the wealthiest children. Without major reforms, ten years from now good health care for children will be just another luxury that only

the most well-to-do American families will be able to afford. At a time when the U.S. stands alone with South Africa as the only industrialized country that does not guarantee health care for all children, we are moving away from, not toward, this basic tenet of all civilized nations.

Health care is extraordinarily expensive. A single immunization against measles in a private physician's office today can cost more than $40.00. A routine dental exam can cost at least $40.00. Checkups for an infant can quickly total more than $300 during the first year of life. A visit to the doctor for strep throat costs $50.00. And if a child has more substantial health care needs, expenses can be staggering -- $1000 in physician fees to set a simple fracture of the arm, $15,000 (on average) for the first few weeks of care for infants born with severe medical problems, $150.00 for a pair of eyeglasses, thousands of dollars to correct a treatable hearing problem.

These are not discretionary family expenditures. A family headed by an unemployed worker or one who earns $25,000 annually and who has not seen a real wage increase in four years cannot simply put off its children's health needs for another day. Given the very high cost of even basic health services and the eroding earnings of families with children (the average weekly earnings of non-supervisory workers dropped by 19 percent between 1973 and 1990), comprehensive health insurance is the only real means virtually all families have to pay for their children's health care.

Declining employer coverage over the past decade has placed millions of children at risk. The employment based insurance

system never worked properly for children. As indirect beneficiaries of their parents' employment based coverage, children were frequently left out because their parents' employers offered no family insurance benefits or offered family coverage only at unaffordable rates, or because they lived with unemployed parents. They might be excluded because work place insurance denied coverage to certain children altogether, such as those who were adopted, who lived with relatives other than parents, or who had pre-existing medical conditions. Even when children did have coverage, it frequently fell far short of meeting their health care needs, forcing families to pay substantial additional sums for necessary medical care out of their own frequently modest earnings.

But by the late 1980s, even in the midst of the most sustained period of economic growth since World War II, the proportion of children with employer-based private health insurance coverage had declined markedly from its already inadequate, mid-1970s level. The number of completely uninsured or inadequately insured children climbed substantially. Moreover, these results reflect surveys conducted in 1977 and 1987 -- before the current recession increased unemployment and sliced employer contributions to fringe benefits. Therefore, the picture today is even grimmer, with more children losing coverage as their parents lose employment or see their earnings reduced.

Children in families that manage to hang onto their jobs are likely to face declining employer contributions to the cost of family insurance plans -- costs that are escalating far faster than the general annual rate of inflation, even as family wages available to pick up these added health care costs remain flat or

drop. As high as the number of children without employer coverage is in any given year, this number masks the millions more who keep their coverage only for relatively brief periods of time before losing it to unemployment, separation and divorce, the death or disability of a working parent, a job change, or a major rise in the cost of family coverage.

It is not just the children who have lost (or who will lose) their coverage who are threatened. Most of the important health services that Americans have come to expect for their children simply cannot be sustained if large numbers of children in a community are without health insurance or are inadequately insured. The cost of services such as neonatal intensive care for infants born ill or disabled, and special health care programs for the one in twenty children with an activity limiting physical or mental health impairment, is too great to be borne without health insurance coverage. Even relatively low cost medical services for pregnant women and children cannot exist in communities without the broad-based financial resources to support them. If the proportion of children without adequate health insurance continues to grow, then much of the health care families have come to rely on for children may become impossible for communities to support, unless the cost of care for the remaining insured children climbs precipitously. When half of all the young patients in a children's hospital are completely uninsured or inadequately insured, then the hospital's very survival is fundamentally threatened -- not just for the uninsured children but for <u>all</u> children.

It is working, moderate income families, whom we think of as providing a strong safety net for their children, whose children

proportionately have been hurt the most by the splintering employer based health insurance system. The decline in private insurance coverage for children in low and middle income, working households (those earning between $11,600 and $46,400 annually for a family of four in 1991 dollars) is a stark example of the fragility of family self-sufficiency in the face of broader social and economic trends. In many ways families are only as strong as the social and governmental institutions which support them. If these institutions begin to crumble, even the most resolute parents cannot overcome their loss.

The voluntary employment based health insurance system is just such a crumbling institution. Over the past 50 years the system has been supported by the federal government at great expense, mainly through special tax laws that exclude from taxable income employer wages paid to workers in the form of group health insurance premiums. In this way, millions of American families have been provided with good health coverage and have been protected from the rapidly rising cost of health care.

The system has worked reasonably well for most families. But it has left out millions more. And now, despite its cost, the system excludes 40 percent of all children under 18. Its cracks have become chasms, far too deep to ignore any longer.

ABOUT THIS REPORT

This report examines children and their place in the employment-based health insurance system. The report uses data from three national studies of health insurance conducted by the

federal government between 1977 and 1990 (discussed in greater detail in Appendix A). It estimates the number of children who are uninsured or underinsured and examines in detail the patterns of declining children's private insurance coverage which occurred between the late 1970s and the late 1980s.

CHILDREN WITHOUT EMPLOYER HEALTH INSURANCE

In 1990, according to data from the United States Census Bureau, forty percent of children under age 18 -- more than 25 million -- lacked employer insurance, the principal form of health insurance for working-age Americans and their families (Table 1A). Although more than 85 percent of all American children live in employed families, only 60 percent had employer insurance in 1990. Of the 25 million without employer coverage, 8.4 million children -- 12.9 percent of all children in the U.S. -- were completely uninsured, either publicly or privately (Table 1A). About 12 million were covered by the Medicaid program. Fewer than 7 million had private insurance derived through a source other than employment, making non-employment-based private insurance a relatively negligible source of coverage for children.[1]

However, even the 25 million children without any employer coverage in 1990 does not tell the whole story. Children have a particularly tenuous connection to the employment based insurance system. A parent's job change, a period of unemployment, a divorce

[1] Moreover, the high cost of non-group purchased private health insurance coverage means that most children insured through these plans probably have only extremely limited coverage for high-cost catastrophic health expenditures.

Table 1A. Health Insurance Coverage Status of All Children Younger than 18, by Race/Ethnicity, 1990

	Total	Covered by Public or Private Insurance	Covered by Any Private Insurance	Covered by Employer-Based Insurance	Covered by Medicaid	Uninsured Throughout the Year
All Races						
Number	65,049	56,634	46,369	39,964	11,993	8,414
Percentage		87.1%	71.3%	61.4%	18.4%	12.9%
White						
Number	51,929	45,444	39,484	34,356	7,132	6,486
Percentage		87.5%	76.0%	66.2%	13.7%	12.5%
Black						
Number	10,162	8,695	4,954	4,048	4,201	1,467
Percentage		85.6%	48.8%	39.8%	41.3%	14.4%
Latino						
Number	7,457	5,344	3,356	2,893	2,237	2,113
Percentage		71.7%	45.0%	38.8%	30.0%	28.3%

Note: Persons of Latino origin may be of any race.

SOURCE: March 1991 Current Population Survey, Bureau of the Census. Calculations by the Children's Defense Fund.

or separation, the death or disability of a working parent, or a sudden dramatic hike in the cost of job-related health insurance premiums for family coverage all can (and do) cause children to experience frequent periods without health insurance. A special federal study examining the duration of insurance coverage indicates that over a 28-month time period, nearly 43 percent of all privately insured children will go for some amount of time without coverage. This means that of the 46 million children with private coverage as of the summer of 1990 (as shown on Table 1A), nearly 20 million will have experienced the partial or complete loss of employer coverage by November, 1992. Thus, the true number of

children at risk is not only the 25 million without employer coverage during a single year, but also the more than two in five privately insured children who will now go without coverage at some point over the next 28 months. In short, the current system is failing millions of children completely and is extremely shaky for millions more.

Table 1B. Health Insurance Coverage Status of All Poor Children Younger than 18, by Race/Ethnicity, 1990

	Total	Covered by Public or Private Insurance	Covered by Any Private Insurance	Covered by Employer-Based Insurance	Covered by Medicaid	Uninsured Throughout the Year
All Races						
Number	13,431	10,500	2,874	1,850	8,313	2,932
Percentage		78.2%	21.4%	13.8%	61.9%	21.8%
White						
Number	8,232	6,159	2,004	1,306	4,609	2,073
Percentage		74.8%	24.3%	15.9%	56.0%	25.2%
Black						
Number	4,550	3,834	744	482	3,305	715
Percentage		84.3%	16.4%	10.6%	72.6%	15.7%
Latino						
Number	2,865	1,939	407	279	1,656	926
Percentage		67.7%	14.2%	9.7%	57.8%	32.3%

Note: Persons of Latino origin may be of any race.

SOURCE: March 1991 Current Population Survey, Bureau of the Census. Calculations by the Children's Defense Fund.

Racial and Ethnic Characteristics of Children without Employer Insurance

Virtually no child is immune from the health insurance crisis. Table 1A shows that in 1990 only two-thirds (slightly more than 66

percent) of all white children had employer coverage. That year, white children comprised 77 percent of all completely uninsured children, as well (Table 1A).

Even more staggering, however, is the plight of black and Latino children. In 1990, only four in ten black and Latino children (39.8 percent and 38.8 percent, respectively) had employer based health insurance coverage. Nearly 30 percent of all Latino children were completely uninsured that year.

Insurance Coverage Among Children Living in Families

In the U.S., children's insurance coverage is tied to their family living arrangements. Children who do not live with two parents are significantly less likely to have employment-based insurance. However, living in a family -- even in a married couple family -- is not enough to assure children coverage. In 1990, almost 3 in 10 children living in married couple families lacked employment based insurance coverage. (Table 2B). Among black children under age 18 living in married couple families in 1990, almost 4 in 10 lacked employer coverage (Table 2B). And among Latino children living in married couple families, more than half lacked employer insurance that year.

The Safety Net Role of Medicaid for Children

Because there is no national health insurance system for children similar to the Medicare program for older (and certain disabled) Americans, "safety net" programs such as Medicaid for poor children play a particularly important role. As Table 1A shows, in 1990 11.9 million children were insured by Medicaid.

Table 2A. Health Insurance Coverage Status of Children Younger than 18 in Families, by Race/Ethnicity, 1990

	Total	Covered by Public or Private Insurance	Covered by Any Private Insurance	Covered by Employer-Based Insurance	Covered by Medicaid	Uninsured Throughout the Year
All Races						
Number	63,908	55,830	45,876	39,645	11,620	8,079
Percentage		87.4%	71.8%	62.0%	18.2%	12.6%
White						
Number	51,024	44,802	39,074	34,076	6,857	6,222
Percentage		87.8%	76.6%	66.8%	13.4%	12.2%
Black						
Number	9,980	8,576	4,894	4,022	4,130	1,404
Percentage		85.9%	49.0%	40.3%	41.4%	14.1%
Latino						
Number	7,297	5,281	3,326	2,874	2,198	2,016
Percentage		72.4%	45.6%	39.4%	30.1%	27.6%

Note: Persons of Latino origin may be of any race.

SOURCE: March 1991 Current Population Survey, Bureau of the Census. Calculations by the Children's Defense Fund.

Without Medicaid the number of completely uninsured children would have stood, not at 8.4 million, but far higher.

Of the 11.9 million children covered by Medicaid in 1990, only 2.2 million were covered by private insurance for even part of the year, according to the Census Bureau. Without Medicaid, some 9.7 million additional children would have had no coverage at all. Thus, in Medicaid's absence, the number of completely uninsured children would have more than doubled -- from 8.4 million to 18.1 million children.

Children's dependence on Medicaid knows neither racial nor ethnic limitations. In 1990 7.1 million of the 11.9 million

Table 2B. Health Insurance Coverage Status of Children Younger than 18 in Married-Couple Families, by Race/Ethnicity, 1990

	Total	Covered by Public or Private Insurance	Covered by Any Private Insurance	Covered by Employer-Based Insurance	Covered by Medicaid	Uninsured Throughout the Year
All Races						
Number	47,962	42,451	38,803	34,012	4,551	5,511
Percentage		88.5%	80.9%	70.9%	9.5%	11.5%
White						
Number	41,601	36,917	34,143	30,126	3,466	4,683
Percentage		88.7%	82.1%	72.4%	8.3%	11.3%
Black						
Number	4,064	3,519	2,957	2,507	701	545
Percentage		86.6%	72.8%	61.7%	17.2%	13.4%
Latino						
Number	5,101	3,613	2,787	2,450	973	1,488
Percentage		70.8%	54.6%	48.0%	19.1%	29.2%

Note: Persons of Latino origin may be of any race.

SOURCE: March 1991 Current Population Survey, Bureau of the Census. Calculations by the Children's Defense Fund.

children receiving Medicaid -- nearly 60 percent -- were white. But Medicaid plays an especially large role in the coverage of minority children. In 1990, slightly more than 13 percent of all white children relied on Medicaid. But over 40 percent of all black children and more than 30 percent of all Latino children depended on Medicaid that year, a testament to their deep impoverishment and their diminished access to private coverage, even when living in employed families.

The role which Medicaid plays for children underscores the crucial importance of the recent expansions in the program to cover all poor children under age 19 by the year 2002. The vast majority

of the children who will be added to Medicaid over time through these reforms are currently without any source of coverage. In the absence of broader national health reforms, Medicaid continues to be virtually the only source of health care financing for poor children.

TRENDS IN PRIVATE INSURANCE COVERAGE OF CHILDREN

Taken alone, the "snapshot" provided by these 1990 Census statistics offers a disturbing picture of children without private health insurance. But the true severity of the 1990 numbers cannot be fully understood without examining the trends which underlie them. In order to identify these trends we studied data from two special national household surveys of health insurance coverage (discussed at greater length in Appendix A) which were conducted by the federal government in 1977 and 1987. These two surveys (the 1977 National Medical Care and Expenditure Survey (NMCES) and the 1987 National Medical Expenditure Survey (NMES)) offer more detailed information about which children lost employer coverage over the decade.

NMES and NMCES are particularly noteworthy sources of information for another reason, as well. The 1977 NMCES survey was conducted during a relative high-water period in the employment based heath insurance system. The great U.S. labor shift away from manufacturing jobs with good pay and fringe benefits and toward lower paying jobs with few benefits had just begun. The 1987 NMES survey was conducted during the fifth year of the longest period of economic recovery (1982-1989) the nation has experienced since

World War II. Employment was at an all-time high, and employment-related insurance coverage should have been, as well. Had the data from the second survey been collected in the midst of the recession (which began in earnest in 1990), the results would undoubtedly have shown an even grimmer insurance crisis confronting children, given the close tie between employment and insurance coverage for working age Americans and their families.

Trends in Employment Related Insurance Coverage of Children By Family Income Level

Table 3 shows that between 1977 and 1987 the proportion of children under 18 covered by employer based private insurance dropped from 72.8 percent to 62.9 percent, a 13.6 percent decline in 10 years. If this trend continues unabated between 1987 and the year 2000, then by the end of the century the proportion of children with employer insurance will stand at 50.0 percent -- just slightly more than half of all U.S. children. Moreover, this estimate probably is low since the recession now causing widespread joblessness and employer payroll cutbacks will accelerate the trend.

Children did not bear the burden of lost health insurance equally. Among children living in the highest income families coverage actually increased slightly. But among poor children overall coverage declined 16 percent, from just 27.5 percent in 1977 to 23.0 percent in 1987 (Table 3). Proportionately, however, the greatest declines occurred among children living in families with incomes between 100 percent and 200 percent of the federal poverty level.

In 1977, an apex year for employment based health insurance coverage, only 63.4 percent of all low income children (those with family incomes between 100 percent and 200 percent of the federal poverty level) had employer coverage (Table 3). By 1987, at the height of the recovery, their rate of employment-related coverage had dropped to 47.0 percent, a 25.9 percent decline over 10 years. Less than half of all children living in low income families had employer coverage that year.

Middle income children (those with incomes between 200 and 400 percent of poverty) also suffered a loss of coverage. In 1977, nearly 83.6 percent had employer coverage. By 1987, only 79.0 percent had employer coverage, a 5.5 percent drop over the decade.

Trends in Private Insurance Coverage of Children By Parents' Employment Status

Just as living with two parents fails to protect children from the eroding private health insurance system, living with employed parents does not protect children, either. Regardless of whether children live with one parent or two, and regardless of whether one or both parents work, the proportion of privately insured children has declined. In 1977, 89.6 percent of all children living with two employed parents (the kind of household most likely to have employer-provided family coverage) were privately insured. By 1987 that proportion had dropped to 87.2 percent, a decline of slightly less than 3 percent. Children living with an employed single parent (who have a lower chance of being privately insured than children in two-parent employed households) experienced a 2 percent decline in private coverage, from 66.0 percent in 1977 to 64.7 percent in 1987. (Table 4)

Table 3. Employment-Related Insurance, by Race/Ethnicity and Income, 1977 and 1987

	1977	1987
All Children		
Total	72.8	62.9
White	78.2	71.3
Black	52.5	38.1
Latino	50.7	39.4
Poor Children (b)		
Total	27.5	23.0
White	40.0	31.5
Black	11.0	15.9
Latino	12.5 (a)	16.1
Low Income Children (c)		
Total	63.4	47.0
White	69.0	52.1
Black	50.5	34.2
Latino	49.6	38.3
Middle Income Children (d)		
Total	83.6	79.0
White	84.2	81.3
Black	83.7	69.5
Latino	71.7	64.5
Upper Income Children (e)		
Total	85.4	86.9
White	86.9	87.3
Black	76.8	83.4
Latino	69.0	77.5

SOURCE: HIES and NMES. Calculations by the Children's Defense Fund.

a. Standard error is greater than 30 percent of the estimate.
b. Incomes below federal poverty level.
c. Incomes between 100 to 199 percent of federal poverty level.
d. Incomes between 200 to 399 percent of federal poverty level.
e. Incomes at 400 percent and above of federal poverty level.

Table 3A. Proportion of Children with Employer Insurance, 1977-2000*

	1977	1987	2000
All children	72.8%	62.9%	50.0%
Black children	52.5%	38.1%	19.4%
Children in two-parent, one wage earner families	83.0%	73.3%	60.7%
Low income children	63.4%	47.0%	25.7%
Middle income children	83.6%	79.0%	73.0%

*Based on average annual rate of change, 1977-1987. Does not take into account possible accelerated loss of employer coverage resulting from the current recession.

SOURCE: HIES and NMES. Calculations by the Children's Defense Fund

However, it was children in two-parent, single wage earner families who experienced the greatest proportional decline in private coverage. It was these families -- the "traditional" family in which one parent is a wage earner outside the home and the other works in the home caring for children -- whose children lost the most ground in relative terms. In 1977 83.0 percent of all children living in two-parent, one-wage earner families had private insurance. By 1987 only 73.3 percent had private coverage, an 11.7 percent decline. In 1977 a two-parent family which chose to have one parent remain at home to care for children suffered a moderate loss in the likelihood of health coverage. By

Table 4. Children With Private Insurance Coverage by Parents' Employment and Race/Ethnicity, 1977 and 1987

	1977	1987
Two Parents, Both Employed		
Total	89.6	87.2
White	90.6	88.8
Black	84.1	85.2
Latino	85.0	72.4
Two Parents, One Employed		
Total	83.0	73.3
White	85.4	77.9
Black	72.4	62.1
Latino	63.9	43.7
All Single Parents, Employed		
Total	66.0	64.7
White	70.8	75.2
Black	62.1	51.0
Latino	37.4	35.9
Single Female Parents, Employed (a)		
Total	64.9	62.9
White	69.5	74.1
Black	62.3	50.7
Latino	35.7	33.5

SOURCE: NMCES and NMES. Calculations by the Children's Defense Fund.

a. Children in single-parent, female-headed families comprise a subgroup of all children in single-parent families.

1987, the cost in terms of health benefits of having one parent remain at home had become far steeper. Families increasingly must have two wage earners, not only for the added income two wage earners can produce, but for the sake of their children's health insurance coverage as well. In effect, two-parent families in which one parent works at home suffer a double penalty -- the loss

of income and the loss of health insurance for their children. If trends in private coverage of children continue, by the year 2000 employer insurance will be the exception rather than the rule for millions of children. Only 50 percent of all children, less than 20 percent of black children will have coverage. Only 60 percent of children in two-parent, one wage earner families, 25.7 of low income children and 73.0 percent of middle income children will have private coverage (Table 3A).

Uninsured Children Living In Employed Families

The decline in employment related private coverage, the absence of a universal, public insurance "safety net" for children without private insurance, and the limitations of Medicaid which, by definition, is virtually confined to poor children drove up sharply the number of completely uninsured children living in employed families. In 1977, 6.3 percent of all children living in two-parent, two wage earner families were completely uninsured. By 1987 that number had climbed to 10.3 percent, a 63 percent increase (Table 5). If this trend continues at the same pace until the year 2000, then by the end of the century 15.5 percent of children in employed households with two wage earners could be completely uninsured.

Particularly hard hit were children in two-parent, one-wage earner families and those in working families headed by a single parent. Between 1977 and 1987 the proportion of uninsured children in two parent, one-wage earner families grew by nearly 64 percent, from 11.3 to 18.5 percent. If this trend continues, then by the year 2000 as many as 27.9 percent of all children living in two-

Table 5. Percentage of Children Without Health Insurance, by Parent's Employment and Race/Ethnicity, 1977 and 1987

	1977	1987
Two Parents Both Employed		
Total	6.3	10.3
White	5.8	8.9
Black	10.2	10.7
Latino	7.2 (a)	23.6
Two Parents One Employed		
Total	11.3	18.5
White	10.3	15.1
Black	16.9	26.4
Latino	17.6 (a)	39.7
All Single Parents Employed		
Total	13.2	22.1
White	12.2	16.8
Black	13.2	28.3
Latino	21.8 (a)	38.0
Single Female Parents Employed (b)		
Total	13.0	22.8
White	12.3	17.1
Black	12.8	28.3
Latino	19.5 (a)	38.9

SOURCE: NMCES and NMES. Calculations by the Children's Defense Fund.

(a) Standard error is greater than 30 percent of the estimate.
(b) Children in single-parent female-headed families comprise a subgroup of all children in single-parent families.

parent one wage earner families will be completely uninsured. Among children living in single parent, wage earner families, the proportion which was totally uninsured grew by more than 67 percent, from 13.2 percent to 22.1 percent (Table 5). By the year 2000, as many as 33.7 percent of these children could be completely

uninsured.

Table 6. Percentage of Uninsured Children Living With Parents Working More than 30 Hours Per Week, by Parent's Employment, 1987

Two parents	85.7
Two Parents Both Employed	88.4
Two Parents One Employed	83.6
All Single Parents Employed	57.1

SOURCE: NMES. Calculations by the Children's Defense Fund.

The children in employed families who are uninsured have parents who are overwhelmingly full-time workers. In 1987, more than eighty five percent of the uninsured children living in two-parent working families, and nearly 60 percent of the uninsured children living in single-parent working families had parents who worked more than 30 hours per week (Table 6).

Trends in Children's Insurance Coverage by Place of Residence

As would be expected, given the nature of employment in rural areas, children who live in metropolitan regions were more likely to be insured in both 1977 and in 1987 than those living outside of these areas. But Table 7 shows that erosions in coverage occurred among both metro and non-metro children over the 10 year period. For children living in SMSAs, the proportion with private insurance declined by 8.6 percent, from 76.7 percent to 70.1 percent. Among rural children the decline in private coverage was an even steeper 13.1 percent, from 73.8 percent with private coverage to just 64.1

Table 7. Children's Insurance Status by Race/Ethnicity and Place of Residence, 1977 and 1987

	1977	1987
No Insurance: SMSA		
Total	9.8	15.6
White	7.2	12.3
Black	11.3	18.7
Latino	13.9 (a)	31.7
No Insurance: Non-SMSA		
Total	15.4	19.2
White	11.8	17.1
Black	21.4	25.9
Latino	26.8 (a)	29.8
Private Insurance: SMSA		
Total	76.7	70.1
White	84.2	80.0
Black	53.4	44.6
Latino	54.0	42.4
Private Insurance: Non-SMSA		
Total	73.8	64.1
White	77.7	71.5
Black	45.7	33.9
Latino	45.4	44.7
Public Insurance: SMSA		
Total	17.0	15.8
White	10.7	9.5
Black	37.6	37.1
Latino	34.5	26.9
Public Insurance: Non-SMSA		
Total	15.0	17.7
White	12.6	12.5
Black	34.0	41.7
Latino	27.9	25.4

SOURCE: NMCES and NMES. Calculations by the Children's Defense Fund.

percent. For both urban and rural children, notable increases in the proportion without any insurance occurred (a 58 percent increase for children living in metropolitan areas and a 24.7 percent increase for children living in rural areas) (Table 7).

Trends in Insurance Coverage Among Minority Children

Where private health insurance coverage is concerned, nearly all children fared poorly between 1977 and 1987. However, the situation was particularly terrible for black and Latino children. These children fell out of the employer based insurance system at high rates, protected by neither their parents' employment status nor their family living arrangements. Their loss of coverage is a stark reminder of the high numbers of black and Latino children living in families -- including two parent, two wage earner families -- who work at jobs that pay poor wages and that carry few, if any, fringe benefits.

Between 1977 and 1987, when the proportion of employer insured children fell by 13.6 percent overall, the proportion of employer insured black children fell by over 27 percent, from 52.5 percent to 38.1 percent. By 1987 black children living in families of any income level were less likely than white low income children to have employer provided health insurance (Table 3). If this 1977-87 trend continues from 1987 until the end of the century, then by the year 2000 less than 20 percent of black children will have employer insurance (Table 3A). Among Latino children, the proportion with employer insurance fell by over 22 percent between 1977 and 1987, from 50.7 percent to 39.4 percent (Table 3).

Among poor black and Latino children, the proportion with

employer insurance actually improved slightly. The proportion of poor black children with employer coverage rose from 11 percent to 15 percent, while the proportion of poor Latino children with employer coverage increased from 12.5 to 16.1 percent (Table 3). Despite these improvements, however, by 1987 poor black and Latino children were only half as likely to have employer coverage in 1987 as poor white children.

Among low income and middle income black and Latino children, however, major declines in employer coverage occurred. Between 1977 and 1987 the proportion of low income black children with employer coverage fell from 50.5 percent to 34.2 percent -- a nearly one-third drop in coverage (Table 3). The proportion of employer insured low income Latino children fell by nearly 23 percent. Middle income black children suffered a 17 percent drop in employer coverage, while Latino children suffered a 10 percent drop (Table 3).

Parental employment provided even less of a buffer against the loss of insurance in the case of black and Latino children than for children generally. Between 1977 and 1987, when the proportion of privately insured children in two-parent, two-wage earner families fell by slightly less than 3 percent overall, the corresponding proportion of privately covered Latino children living in such families fell by more than 14 percent, from 85.0 percent to 72.4 percent (Table 4). Moreover, the proportion of privately insured black and Latino children living in two-parent, one wage earner families declined disproportionately. Among black children, the proportion declined by more than 14 percent (from 72.4 percent to 62.1 percent). Among Latino children the proportion with private

coverage fell by more than one 30 percent, from 63.9 percent to 43.7 percent (Table 4). An 18 percent drop occurred in private coverage among black children living in working families headed by a single parent, even as the proportion of privately insured white children living in such families increased (Table 4).

Similar large racial and ethnic gaps can be seen when insurance coverage by place of residence is considered. In 1987, when 80 percent of all white children living in SMSAs had private coverage, only 44.6 percent of black children and 42.4 percent of Latino children had private coverage (Table 7). In 1987 a rural black child was less than half as likely as a rural white child to have private insurance (Table 7).

Most shocking, perhaps, is the proportion of completely uninsured minority children living in employed families. In 1987, 26.4 percent of all black children and nearly 39.7 percent of all Latino children living in two-parent, one wage earner families were completely uninsured (Table 5). Nearly 30 percent of all black children and nearly 40 percent of all Latino children living in single parent working families were completely uninsured in 1987 (Table 5). And nearly one-quarter of all Latino children living in two-parent, two-wage earner families were completely uninsured in 1987 (Table 5). Between 1977 and 1987 the number of completely uninsured white children living in two-parent families with one wage earner grew by 47 percent. Among black children, the growth was 56 percent.

THE ADEQUACY OF COVERAGE FOR INSURED CHILDREN

Even when parents are able to maintain their children's private coverage, (and evidence from federal studies shows that, regardless of income, nearly all families will purchase workplace coverage for their children if offered) they have watched their out-of-pocket premium, deductible and coinsurance costs skyrocket. Escalating family insurance premium costs not (or no longer) borne by employers undoubtedly have played a significant role in the declining coverage of children in working families. Many families simply can no longer afford the cost of family coverage. According to the United States Department of Labor, between 1980 and 1989, the proportion of workers participating in medium and large sized insurance plans who were required to contribute to the cost of family coverage rose from 46 percent to 64 percent, with the out-of-pocket cost for monthly coverage averaging $71.41 by 1989.

Escalating uncovered family health insurance costs have also hurt in other ways. As the cost of premiums rises, it eats into the amount of money families have to pay for necessary, but uncovered, medical care for their children. Just maintaining insurance coverage to protect children in the event of high cost, catastrophic health expenditures can easily force families to forego the far more frequent expenditures for the relatively low cost and effective but uncovered health services that all children need -- routine health exams for infants and children, dental care, immunizations, eyeglasses, and other essential but commonly uncovered services. For families with children who have chronic health problems, the choices posed by escalating, uncovered

premiums for inadequate family health insurance coverage are simply untenable.

CONCLUSIONS AND RECOMMENDATIONS

The denial of effective and necessary health care to even a single child is unacceptable. It is completely unconscionable that a country as wealthy as our own, which spends more per capita on health care than any other nation, should make even basic care an all but unaffordable luxury for tens of millions of children. No excuses can justify the current situation. We have the resources to provide health insurance to all Americans. Indeed, our most important world competitors, such as Japan and Germany, have managed to combine strong economies with guaranteed health care for all children. We have the money -- and we have the means -- to make health care a right for all American children. All we lack is the will.

Over the past decade substantial strides have been made in providing at least some modicum of relief to the poorest children. The Medicaid expansions enacted between 1988 and 1990 mean that by the year 2002 all poor children under age 19 will be eligible for benefits. Tax credits enacted by Congress in 1990 provide some potential financial relief for working poor families with children who have access to employer provided coverage but who cannot afford its cost. But these reforms, as important as they are, are only a beginning. They do not reach children living in low and middle income working families whose children are losing their health insurance.

The Medicaid reforms represent a vital buffer against the catastrophe of being without insurance at all. But they also suffer serious shortcomings. Tied to stringent tests of financial eligibility, Medicaid coverage is even more fleeting than employer benefits. A few dollars in monthly earnings can completely disqualify a child whose family income is at the Medicaid eligibility ceiling. Young children cannot qualify for Medicaid unless they have poverty level incomes. Moreover, all but five states (Alaska, California, Connecticut, New York and Vermont) deny Medicaid to poor children over age 9, because the poverty-level Medicaid improvements enacted in 1990 are phased in only for children born after September 30, 1983. Children born before this date in 45 states and the District of Columbia face Medicaid eligibility standards averaging less than 50 percent of poverty, with many states still excluding children over age 9 in two-parent working households no matter how poor. Less than half of all states extend Medicaid to all pregnant women and infants with family incomes under 185 percent of the federal poverty level.

For children and pregnant women who do have Medicaid, low provider reimbursement levels (and the welfare stigma so frequently and unreasonably attached to it) make the program a weak substitute for health insurance. The Medicaid benefits are among the broadest available to children. But all too often, children covered through Medicaid have serious health care access problems (particularly access to primary health services) because so many physicians either refuse to treat Medicaid patients at all or else place severe limits on the number they will serve.

What is needed is a national health program that assures

access to health care for all children, regardless of family income, employment status, family living arrangements, place of residence, race or ethnicity. There are three basic elements which any national health plan responsive to the needs of children should incorporate. The first is insurance coverage. All families must be assured of health insurance. At a minimum, however, a national health plan should guarantee immediate coverage for all children and pregnant women.

An insurance plan that meets the needs of children would include: coverage that begins with comprehensive health services during pregnancy and that continues throughout childhood and into young adulthood; comprehensive benefits, including maternity care, routine health exams, immunizations, vision care, dental care, hearing care, medical care for common child health problems, and long-term medical and remedial services for children with chronic physical, mental and developmental illnesses, disabilities and delays. The plan should set premiums that are tied to family income and should keep deductibles and coinsurance low. It should also contain an all-inclusive provider fee schedule that eliminates the practice of "balance billing", under which providers charge patients beyond the amount paid by an insurance plans. Finally, the plan should provide for an easy and swift enrollment.

The second element of a sound maternal health plan for children is funds for the development of health services in areas of the country suffering from a shortage of primary care. Currently more than 30 million medically underserved Americans, living largely in inner cities and rural communities, have insufficient access to even the most basic health services. Two-thirds of the

medically underserved are women of childbearing age and children. Without a health services development component which builds on programs of proven effectiveness (such as community and migrant health centers, comprehensive public health clinics serving children, and the National Health Service Corps), even the most comprehensive health insurance coverage may do little to improve medically underserved children's access to primary health care.

Third, even with national health insurance and the development of additional health services, there will remain the need for a strong public health system. Essential to everyone's health is a basic public health infrastructure which oversees services to control the spread of communicable disease, provides basic public health services such as immunizations and vaccine distribution, and conducts ongoing outreach and preventive health activities for communities and populations with special health needs. A strong public health infrastructure remains a hallmark of nations with comprehensive national health insurance systems.

In structuring national health insurance benefits (whether for children alone in the beginning or, ideally, for children and their families simultaneously), two basic approaches could be taken. The first is to establish a "single payor" system analogous to Medicare. Under this system, all children and pregnant women would be covered by a single insurance plan administered either by the government or (as is the case with Medicare) by private insurers operating on a regional basis or at the state level. The second approach is establishment of a "multi-payor" system, under which children and families would be insured either through private group health pools (through employers or other settings) or through a

public insurance plan. The new public plan would replace Medicaid.

A single payor system is probably the best model for children, since it is structured to operate independently of the employment setting, thereby protecting children from the loss of health insurance as a result of changes in family living arrangements or parental employment status. Moreover, as numerous studies have shown, a single payor system would be more cost efficient and would therefore permit broader coverage, lower premiums, deductibles and coinsurance, and better reimbursement rates to health care providers.

However, while a "single payor" system is preferable, it may not be a practical immediate first step. For two genera-tions, children have been insured through their parents. Establishing a single payor insurance system represents a con-ceptual break with the past 50 years' practice. Regardless of the benefits of establishing a Medicare-like program for children and families, the tendency in American social policy is to move in an evolutionary fashion. With so many Americans still insured through employer plans, proposals that complement rather than replace the current system may be more conceptually acceptable.

Moreover, as cost efficient and equitable as a single payor system would be, the single payor proposals introduced to date are opposed by insurers and health care providers. Given the urgency of the problem facing children it is not worthwhile to delay major reforms while the merits of single versus multi-payor plans are debated. With 25 million children excluded from the mainstream health insurance system and with the numbers sure to rise still further, endless arguments over the form that national health

insurance will take simply cannot be endured any longer.

Particularly unacceptable are so called national health reform proposals that guarantee nothing for anyone. The tax credit plan now being fashioned by the White House does not guarantee a health insurance card, doctor, or clinic to a single American child. A few hundred dollar credit does nothing for families facing costs of $3,000 per year or more for group health coverage and making $20,000. A credit of a few hundred dollars cannot heal a child's strep throat. A tax credit does not correct a child's vision problem. The credit does nothing for a family without access to health insurance. American children, like children throughout the industrialized world, need health care, not tax credits.

The great tragedy of the current health debate is that it has occurred so many times before in this country, and that each time, it has become mired down in structural and philosophical disagreements. With each failed national health reform cycle, the existing system has eroded still further. Now there simply is no more time for philosophical arguments. If children's free fall out of the health care system is to end, the nation must move forward swiftly.

To provide all children and pregnant women with adequate health coverage, to develop health services in all communities in which they are needed, and to strengthen public health activities, would cost approximately an additional $10 billion annually beyond what is now spent on child health. The $10 billion investment in children represents an approximate 1.5 percent increase in the nation's 1990 health care bill. It does not include off-setting savings resulting from children's improved access to such cost

effective health services as comprehensive maternity care (more than $3.00 saved for every dollar spent), routine health care (resulting in annual child health costs that are 10 percent lower than for children who do not receive such care), and immunizations (between $10.00 and $14.00 saved for each dollar spent).

It has been more than 70 years since the first national health debates took place. Over this time, a massive, voluntary system of employer-provided health insurance evolved, extending coverage to more than 150 million working age Americans and their families. Now, however, that system is in disarray, and there is no more visible sign of its decline than the unraveling of coverage for children. One of the most critical issues in this Presidential election will be whether a national health plan will finally be enacted or whether national leaders will once again avoid the problem as one that is too complex, too expensive, too politically unwieldy, and too intellectually difficult to tackle.

Children cannot afford to have national leaders opt out of the national health debate, and neither can the national health budget. In 1989, the White House Task Force on Infant Mortality concluded in a still unpublished report that each infant death costs the nation nearly a half million dollars in medical care costs and lost productivity. Every child who grows up with preventable health conditions is both an individual tragedy and a drain on the medical care system and the economy generally. The time for "voluntary" remedies has passed. No parent in the wealthiest nation on earth should have to wonder where the money to pay his doctor and dentist bills will come from or choose between immunizing the children or paying the rent on time. These are choices that no civilized

nation expects its families to make. 1992 must be the year in which all American children are provided a floor of health care decency.

APPENDIX A: TECHNICAL NOTES

This report relies on three sources of data: Current Population Survey on Poverty in the United States , 1990 (CPS) (Consumer Income Series P-60, No. 175) compiled by the United States Census Bureau; and the National Medical Care and Expenditure Survey (NMCES) and the National Medical Expenditure Survey (NMES), both of which were conducted by the United States Department of Health and Human Services. Because the data for CPS and NMCES/NMES were compiled at different times and using different survey instruments, total population numbers and the percentages of children with different types of insurance coverage vary somewhat. We have used the census data to provide a "snapshot" of which children were insured in 1990, and NMES/NMCES to chart trends. The 1987 NMES study, however, was constructed in a compatible fashion to the 1977 NMCES study in order to permit comparisons.

The Current Population Survey

CPS measures insurance coverage among the civilian, non-institutionalized population and members of the Armed Forces living either off-post or on-post with their families. The civilian population includes both civilians living in metropolitan and non-metropolitan areas. Poverty, as defined by the Census Bureau, covers money income received (exclusive of certain money receipt such as capital gains) before payment for personal income taxes, Social Security, union dues, Medicare deductions, and health care costs. Money income does not reflect the fact that some families receive part of their income in the form of non-cash benefits such as employer-paid health insurance premiums, Medicare, or Medicaid.

Of particular importance is the fact that the Medicaid statistics in CPS may overcount the number of Medicaid insured children. The Census Bureau assumes that all children under age 21 are covered by Medicaid if either the householder or spouse is covered. This counting practice may treat as Medicaid eligible many non-Medicaid eligible children (children older than the age cut-off for poverty-level Medicaid coverage, which is children born after September 30, 1983). This may happen in the case of children living with parents who are covered because a woman is pregnant or because one or both parents are disabled.

The National Medical Care and Expenditure Survey of 1977 and The National Medical Expenditure Survey of 1987

The 1977 NMCES study and the 1987 NMES studies are both year-long surveys of medical care use, expenditures, and health insurance coverage of the U.S. population. Information on race, insurance coverage, employment, and income was derived from the household components of each study. The NMCES household component surveyed approximately 16,000 households consisting of 40,000 individuals. NMES surveyed approximately 15,000 households consisting of 36,000 individuals. Both NMCES and NMES estimates of health coverage are point-in-time estimates for the fourth quarter

of 1977 and 1987, respectively.

In contrast to the 1987 NMES household survey, respondents to the 1977 NMCES household survey were not asked whether their private insurance was employment-related or purchased directly from an insurance company. This information was collected from the Health Insurance Employer Survey (HIES), which supplemented the 1977 NMCES household component. HIES was administered to a subsample of household respondents and includes information on all private health insurance of household members in 1977. Since our estimates of children's health insurance coverage are for the fourth quarter of 1977, we designated a child's private insurance as employment-related if HIES reported that the child had such coverage at any time in 1977.

Data presented here relating to the poverty status of children in 1977 may overstate or understate. Whereas 1987 information is for the fourth quarter (like other information) 1977 poverty status is for the full year.

Comparisons between 1977 and 1987 by race require one caution. While all children in 1987 were assigned a race/ethnicity, some children in 1977 had an unknown race. This occurred either because the child's parent did not designate a racial/ethnic category or the family was not interviewed during the round in which questions regarding race were asked. Distributions of the unknown group according to insurance coverage, income and parent's employment suggest that this population of children is a composite of all racial groups, though predominately composed of white children. Children with unknown race were excluded from the population totals in this analysis.

APPENDIX B: NMCES and NMES Population Tables

Table 3B. Employment-Related Insurance, by Race/Ethnicity and Income, 1977 and 1987

	1977	1987
All Children		
Total	44,813,080	42,064,311
White	38,268,931	35,448,278
Black	4,461,612	3,843,507
Latino	2,082,537	2,772,526
Poor Children (b)		
Total	2,073,222	3,051,674
White	1,696,522	1,895,070
Black	261,816	715,135
Latino	114,884 (a)	441,469
Low Income Children (c)		
Total	8,328,844	6,600,159
White	6,356,597	5,003,891
Black	1,290,036	834,520
Latino	682,211	761,748
Middle Income Children (d)		
Total	22,474,296	19,521,123
White	19,489,028	16,804,468
Black	2,152,907	1,602,925
Latino	832,361	1,113,730
Upper Income Children (e)		
Total	11,936,718	12,891,354
White	10,726,784	11,744,847
Black	756,853	690,927
Latino	453,081	455,580

SOURCE: HIES and NMES. Calculations by the Children's Defense Fund.

a. Standard error is greater than 30 percent of the estimate.
b. Incomes below federal poverty level.
c. Incomes between 100 to 199 percent of federal poverty level.
d. Incomes between 200 to 399 percent of federal poverty level.
e. Incomes at 400 percent and above of federal poverty level.

Table 4B. Children With Private Insurance Coverage by Parents' Employment and Race/Ethnicity, 1977 and 1987

	1977	1987
Two Parents Both Employed		
Total	20,295,957	23,234,241
White	17,542,774	19,872,759
Black	1,868,973	1,758,367
Latino	884,210	1,603,115
Two Parents One Employed		
Total	21,023,923	14,535,008
White	18,660,541	12,752,190
Black	1,310,817	896,243
Latino	1,052,565	886,575
All Single Parents Employed		
Total	3,442,301	6,360,121
White	2,405,076	4,699,993
Black	901,504	1,270,594
Latino	135,721	389,534
Single Female Parents Employed (a)		
Total	2,877,732	5,503,216
White	1,951,882	39,449,952
Black	813,311	1,213,395
Latino	112,539	344,869

SOURCE: NMCES and NMES. Calculations by the Children's Defense Fund.

a. Children in single-parent, female-headed families comprise a subgroup of all children in single-parent families.

Table 5B. Children Without Health Insurance, by Parent's Employment and Race/Ethnicity, 1977 and 1987

	1977	1987
Two Parents Both Employed		
Total	1,431,865	2,743,044
White	1,129,074	2,000,023
Black	227,201	219,919
Latino	75,589	523,102
Two Parents One Employed		
Total	2,860,686	3,660,634
White	2,261,915	2,473,671
Black	307,372	381,159
Latino	291,399	805,804
All Single Parents Employed		
Total	685,542	2,168,227
White	414,200	1,051,268
Black	192,279	703,989
Latino	79,063	412,970
Single Female Parents Employed (b)		
Total	574,838	1,990,734
White	346,103	912,070
Black	167,274	678,525
Latino	61,461	400,139

SOURCE: NMCES and NMES. Calculations by the Children's Defense Fund.

(a) Standard error is greater than 30 percent of the estimate.
(b) Children in single-parent female-headed families comprise a subgroup of all children in single-parent families.

Table 6B. Uninsured Children Living With Parents Working More than 30 Hours Per Week, by Parent's Employment, 1987

All Two Parent Families	5,403,096
Two Parents Both Employed	2,444,972
Two Parents One Employed	3,018,124
All Single Parents Employed	1,230,935

SOURCE: NMES. Calculations by the Children's Defense Fund.

Table 7B. Children's Insurance Status by Race/Ethnicity and Place of Residence, 1977 and 1987

	1977	1987
No Insurance: SMSA		
Total	4,206,604	7,651,744
White	2,662,419	4,394,253
Black	1,016,777	1,419,828
Latino	527,407	1,837,663
No Insurance: Non-SMSA		
Total	3,082,977	3,520,499
White	2,415,088	2,453,279
Black	515,549	660,754
Latino	152,341	406,467
Private Insurance: SMSA		
Total	32,929,286	34,468,269
White	27,280,486	28,632,285
Black	3,688,883	3,381,520
Latino	1,959,916	2,454,463
Private Insurance: Non-SMSA		
Total	14,793,069	11,765,808
White	13,682,300	10,264,865
Black	876,499	890,059
Latino	234,270	610,884
Public Insurance: SMSA		
Total	7,309,603	7,762,607
White	3,460,414	3,397,333
Black	2,597,203	2,809,078
Latino	1,251,986	1,556,197
Public Insurance: Non-SMSA		
Total	3,015,382	3,243,797
White	2,219,175	1,801,724
Black	652,363	1,094,641
Latino	143,844	347,432

SOURCE: NMCES and NMES. Calculations by the Children's Defense Fund.

(a) Standard error of the estimate is greater than 30 percent.